MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2008

AETNA HEALTH INC.

(A Colorado Corporation)

6501 S. Fiddler's Green Circle, Suite 310
Greenwood Village, CO 80111-5039

NAIC Company Code 95256
NAIC Group Code 0001

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

AETNA HEALTH INC.
(A Colorado Corporation)
6501 S. Fiddler's Green Circle, Suite 310
Greenwood Village, Colorado 80111-5039

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2008

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

Damion J. Hughes

And

Independent Contract Examiners

Kathleen M. Bergan, CIE

Howard Quinn, AIE, CCP, CLU, ChFC

October 15, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Aetna Health Inc., a Colorado Corporation (the Company), was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which authorize the Insurance Commissioner to examine health maintenance organizations (HMOs). The Company's records were examined at its Denver office located at 6501 S. Fiddler's Green Circle, Suite 310, Greenwood Village, Colorado, 80111-5039, by Division of Insurance (Division) examiners and independent contract examiners. The contract examiners also reviewed selected electronic records off-site. The market conduct examination covered the period from January 1, 2008 through December 31, 2008.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

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COMPANY PROFILE

The following profile is based on information provided by the Company:

Aetna Health Inc. (AHI) (a Colorado Corporation) operates as an Individual Practice Association (IPA) model HMO. AHI was first incorporated as Frontier Community Health Plans, Inc. on June 21, 1995. On April 9, 1997 the HMO adopted from Aetna U. S. Healthcare, Inc. (which was dissolved on March 28, 1997) the name Aetna U. S. Healthcare of Colorado, Inc. The name of the HMO was changed to Aetna U. S. Healthcare Inc. effective December 15, 1998, and subsequently adopted the current name of Aetna Health Inc. on May 1, 2002.

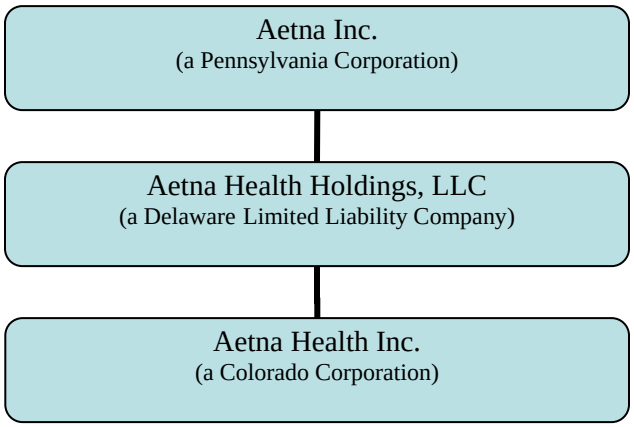
The Company is a direct, wholly owned subsidiary of Aetna Health Holdings, LLC (AHH), a Delaware limited liability company. AHH is a direct wholly owned subsidiary of Aetna Inc. (Aetna), a Pennsylvania corporation. Aetna is a publicly traded corporation, which is the ultimate parent of the Company as defined in Colorado Insurance Regulation 3-4-1.

As a member of the Aetna holding company system, the Company has numerous affiliates. The Company does not own any subsidiaries.

The Company obtained a Certificate of Authority with the Colorado Division of Insurance on July 17, 1995 and is currently licensed in the following counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, Larimer, Mesa, Pueblo, Teller and Weld. The Company is a domestic HMO and is not licensed in nor does it operate in any other state.

STRUCTURE AS OF DECEMBER 31, 2008

An abbreviated organizational chart depicting the Company's relationship with its ultimate controlling person and other affiliates, as of December 31, 2008 is presented below.



Plan of Operation:

The Company's health care service products are offered on a group basis. All marketing, advertising and sales activities are performed by Aetna Health Management, LLC (AHM) a Delaware limited liability company, for the Company under the terms of the Administrative Service Agreement with AHM.

Certain administration services, including accounting and processing of premiums and claims are provided by Aetna Health Management, LLC, a wholly owned subsidiary of Aetna Health Holdings LLC.

Health Care Delivery:

As an Individual Practice Association (IPA) model HMO, the Company contracts directly with a broadly dispersed group of physicians to provide services to enrollees at the physicians' facilities. The Company also contracts with other health care providers and provider organizations to provide comprehensive health care benefits to enrollees.

Primary lines of business are comprehensive medical and federal employee health benefit plans. Primary product types are HMO and point of service. Claim payments are primarily capitation, fee-for-service and contractual.

Aetna Health Inc. is licensed to operate as a health maintenance organization in Colorado.

Aetna Health Inc. does not offer products on the individual or small group level.

Enrollment as of December 31, 2008:	40,691

Premium and Market Share as of December 31, 2008:

Total Written Premium:	$170,724,000*
Large Group Written Premium:	$153,143,000*

Market Share (as a percentage of Colorado Total Accident and Health): 3.05%

*As shown in the 2008 Edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE

Division examiners and independent contract examiners for the Division, in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), and 10-16-416, C.R.S., which empower the Commissioner to examine any HMO, reviewed certain business practices of Aetna Health Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to HMO's. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or supplied by the Company. The limited market conduct examination covered the period from January 1, 2008, through December 31, 2008.

The examination included review of the following:

Company Operations and Management
Producers
Contract Forms
New Business Applications and Renewals
Rating
Cancellations/Declinations/Non-Renewals
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to HMOs. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance company product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an

exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance threshold were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – loss ration guarantees – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-109, C.R.S.	Rules and regulations.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Powers of health maintenance organizations.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-413, C.R.S.	Prohibited practices.
Section 10-16-416, C.R.S.	Examination.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-4	Maintenance of Offices in this State
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests

Insurance Regulation 4-2-5	General Hospital Definition
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing And Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-20	Concerning the Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-2	Group Coordination of Benefits
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form and Eligibility Requirements
Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado

Prior Examinations

The Company was the subject of two previous market conduct examinations by the Division. The first examination covering calendar year 1998, was completed in March of 2000, while the second examination covering calendar year 2002, was completed March 12, 2004. The Company was also the subject of a previous financial examination which was completed June 20, 2008, for the period of July 1, 2004, and December 31, 2006.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, claims and underwriting guidelines/procedures, and timely cooperation with the examination process.

Producers

The examiners reviewed the licensing status of the submitting producers for the samples of the files selected in the new business applications section of the examination for compliance with the appropriate Colorado statutes and regulations.

Contract Forms

The examiners reviewed the following forms:

- The Company Co-payment Schedules, Evidences of Coverage and Schedule of Benefits, and Prescription Drug Riders;

- The Company's most commonly sold group contracts marketed to large groups;
- The Company's conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee applications/enrollment forms and supporting documents.

These forms were issued and/or certified with the Division between January 1, 2008 and December 31, 2008.

New Business Applications and Renewals

For the period January 1, 2008 through December 31, 2008, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- The entire population of forty-two (42) approved large group new business application files; and
- A random sample of eighty-four (84) of the total population of 298 renewed large group files.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the new business applications section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Cancellations/Declinations/Non-Renewals/Rescissions

The examiners reviewed the entire population of ninety-seven (97) cancelled or non-renewed files and seventy-nine (79) declined applications for compliance with statutory requirements and contractual obligations. There were no rescissions during the examination period.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- One hundred nine (109) paid claim files for accuracy of processing
- One hundred nine (109) denied claim files for accuracy of processing
- One hundred eight (108) electronically received paid claim files processed in greater than thirty (30) days
- One hundred eight (108) non-electronically received paid claims files processed in greater than (45) days
- One hundred eight (108) paid claim files processed in greater than ninety (90) days.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The review included the Company's overall utilization review handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law.

The examiners selected for review the following random samples from the total of 14,746 utilization reviews conducted during the examination period.

Standard Utilization Review Determinations

Approved:	One hundred sixteen (116) from a population of 13,636
Denied:	One hundred fourteen (114) from a population of 1,109

Appeals

Total:	One hundred twenty-four (124)
First Level:	The total population of one hundred nine (109)
Second Level:	The total population of nine (9)
External:	The total population of six (6)

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-five (25) findings in which the Company did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Operations and Management: There were two (2) areas of concern identified by the examiners in their review of the Company's Operations and Management:

Issue A1: Failure to include some required provisions in HMO provider contracts.

Issue A2: Failure, in some instances, to maintain records required for market conduct purposes.

Contract Forms: There were eleven (11) areas of concern identified by the examiners in their review of the Company's Contract Forms.

Issue E1: Failure, in some instances, to provide HMO contact information in evidence of coverage forms.

Issue E2: Failure, in some cases, to provide accurate information regarding Newborn and Adoptive Child Enrollment.

Issue E3: Failure, in some instances, to provide accurate information regarding coverage for dependents to age twenty-five.

Issue E4: Failure, in some instances, to provide accurate information regarding the responsibility for tracking copayments.

Issue E5: Failure to provide a required Disclosure Notice in the HMO Certificate of Coverage Form.

Issue E6: Failure, in some instances, to provide for coverage to continue after refusal of treatment recommended by a participating provider. ***(This was prior issue E3 in the findings of the 2002 final examination report.)***

Issue E7: Failure, in some cases, to provide accurate information regarding coverage for therapies for congenital defects and birth abnormalities.

Issue E8: Failure, in some instances, to proscribe the use of genetic testing in connection with a pre-existing condition.

Issue E9: Failure to correctly define a significant break in coverage in the Certificate of Coverage forms.

Issue E10: Failure to correctly state the member's responsibility for payment of charges for non-covered services for which there was a referral in the Certificate of Coverage form.

Issue E11: Failure, in some instances, to provide accurate information regarding eligibility for conversion coverage.

Rating: In the area of rating, no compliance issues are addressed in this report:

New Business Applications and Renewals: In the area of new business applications and renewals, no compliance issues are addressed in this report:

Cancellations/Non-Renewals/Declinations: There was one (1) area of concern identified during the review of the cancellation, non-renewal and declination files.

Issue H1: Failure to reflect a complete definition of a "significant break in coverage" in certificates of creditable coverage.

Claims: The examiners identified five (5) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some cases, to pay late payment interest and/or penalties on claims not processed within the required time periods.

Issue J3: Failure, in some cases, to send a written explanation within thirty (30) calendar days after receipt of an unclean claim, and/or failure to give a full and correct explanation of what additional information is needed to resolve the claim.

Issue J4: Failure, in some cases, to provide true and accurate statements in provider and/or member notices regarding the reasons claims were denied.

Issue J5: Failure, in some instances, to pay eligible charges on claims.

Utilization Review: The examiners identified five (5) areas of concern in their review of the Company's Utilization Review procedures:

Issue K1: Failure, in some instances, to provide a written notice to the covered person at least twenty (20) days prior to the scheduled review date.

Issue K2: Failure, in some instances, to ensure that the second level review panel is comprised of health care professionals with the appropriate expertise in relation to the case being presented.

Issue K3: Failure, in some instances, to include the names, titles or qualifying credentials of the reviewer or members of the review panel in the Company's second level review decision notification letter.

Issue K4: Failure, in some instances, to demonstrate an understanding of a covered person's request for review, and failure to provide the procedures for obtaining an independent external review of an adverse determination. *(This was prior issue K8 in the findings of the 2002 final examination report and K3 in the previous 2000 final examination report)*

Issue K5: Failure, in some instances, to include the name, title and qualifying credentials of the physician who evaluated the appeal and/or the qualifying credentials of the clinical peer(s) with whom the physician consulted in first level review decision letters. *(This was prior issue K8 in the findings of the 2002 final examination report and K3 in the*

previous 2000 final examination report)

Issue K6: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

AETNA HEALTH INC.

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure to include some required provisions in HMO provider contracts.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers states in part:

> (1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:
>
> (a) The contract shall contain a provision stating that neither the provider nor the carrier shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.
>
> (b) The contract shall contain a provision that states the carrier shall not terminate the contract with a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.
>
> …
>
> (d) The contract shall contain a provision that the provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states in part:

> (3) *Every contract between a carrier and a participating provider shall set forth a hold harmless provision specifying that covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier.* Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayments as specifically provided in the covered person's contract with the managed care plan. [Emphasis added.]

Colorado Insurance Regulation 4-2-15, Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Providers, promulgated under the authority of §§ 10-1-109 and 10-16-121(5), C.R.S., states in part:

> V. Rules

I. *Each and every contract between a carrier that has covered lives in Colorado* and a provider or its representative that concerns the delivery, provision, payment, or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended after January 1, 1997, *shall contain provisions substantially similar to the following:*

A. *"No individual or group of providers covered by this contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice* of [name of carrier] or an entity representing or working for the carrier (e.g., a utilization review company)."

B. "[Name of carrier] or an entity representing or working for the carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group or providers covered by this contract."

C. *"[Name of carrier] shall not terminate this contract because a provider covered by this contract expresses disagreement with a decision by [name of carrier] or an entity representing or working for such carrier to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier 's decision,* or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients." [Emphases added.]

Colorado Insurance Regulation 4-7-1, Health Maintenance Organizations, promulgated under the authority of §§ 10-16-401(4)(o) and 10-16-16-403(2)(b), C.R.S., states in part:

Section 12 Provider Agreements

B. In order to qualify as a covered expenditure, a provider, intermediary, IPA or other provider group contract or provider subcontract must have a "hold harmless" provision which substantially complies with the following:

4. *Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner has received written notification of proposed change.* [Emphasis added]

It appears that the Company's provider contracts are not in compliance with Colorado insurance law in that they do not contain a provision that allows a provider to protest a decision by the Company or assist the member patient with a reconsideration of a Company decision without penalty or termination of the contract with the provider. There is also no provision in the physician contracts stating that there are no financial disincentives that would discourage a provider from referring members to other providers in the health plan. In addition, the HMO provider contracts do not include language that any modification to the

"hold harmless" provision will not be effective until thirty (30) days after the Commissioner has received written notification of the proposed changes.

Contract:	Date:
CO/Primary Care Physician Agreement	2.07
CO/ Hospital Services Agreement	2.07

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§10-16-121, and 10-16-705, C.R.S., and Colorado Insurance Regulations 4-2-15 and 4-7-1. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable provider contracts to include all provisions required by Colorado insurance law.

Issue A2: Failure, in some instances, to maintain records required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

Section 3. Definitions

D. *"Claims records" mean:*

(3) *For health:* the notice of the claim, claim forms, bills, electronically submitted bills, proof of loss, *correspondence to and from insureds and claimants or their representatives regarding claim,* claim investigation documentation, health facility pre-admission certification or utilization review documentation where applicable to the claim, claim handling logs, *copies of explanation of benefit statements,* copies of checks or check numbers and amounts, releases, complaint correspondence, *all applicable notices, and correspondence used for determining and concluding claim payments or denial, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.* [Emphases added.]

Section 4. Records Required For Market Conduct Purposes

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to,* company operations and management, policyholder services, *claims practices,* rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years. [Emphases added.]

Section 5. Claims Records

The claims records shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim records shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

A. *The record shall include at least* the notification of the claim, proof of loss (or other form of claim submission) claim forms, proof of claim payment check or draft, notes, contract, declaration pages, information on types of coverage, endorsements or riders, work papers, *any written communications, any investigation, payment or denial of the claim, and any* claim manuals or *other information necessary for reviewing the claim.* Where a particular document pertains to more than one record, insurers may satisfy the requirements of this paragraph by making available, at the site of a market conduct examination, a singe copy of each document. [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that it does not maintain sufficiently clear and specific claim records so that it can readily identify claims that are received in non-electronic form and provide an accurate list for sampling as well as complete documentation of its handling of each claim. Of the 107 claims initially selected from the total population of 2,467 claims paid, denied or settled more than forty-five (45) days after receipt, forty-nine (49) were later determined to have been received electronically. Forty-nine (49) replacement claims were randomly selected from a population verified as non-electronic claims. Of those forty-nine (49) claims, the Company was unable to provide complete claim documentation for five (5) claims. One (1) final sample claim was randomly selected bringing the total random sample to 108 as required for the total number of non-electronic claims paid, denied or settled more than forty-five (45) days after receipt.

In addition, the Company was unable to provide one or more documents requested by the examiners pertaining to ten (10) claims from the denied sample of 109 claims.

Colorado insurance law requires the Company to correctly identify the submission type (electronic vs. non-electronic, in order to determine the correct time period within which they must be processed. In addition, it requires the Company to maintain its records in such a manner that its claims practices may be readily ascertained during market conduct examinations. Although the Company did find a way to identify and provide a sample of true non-electronic claims, five (5) of the replacement sample claims had missing documents which the Company stated it could not provide.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its internal procedures and systems so that all claims records are retained, can be correctly identified and can be made available for review as required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure, in some instances, to provide HMO contact information in evidence of coverage forms.

Colorado Insurance Regulation: 4-7-2, Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts And Services In Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

A. HMO Information

> *The contract and/or evidence of coverage shall contain th*e name, address, and *telephone number of the HMO* and shall describe how services may be obtained. A toll free or collect call phone number within the service area for calls, without charge to enrollees, to the HMO's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for member services, problems, or questions. [Emphasis added.]

Form:		Date:
HMO/CO-COC-7	Certificate of Coverage	07/07
HMO CO SB-7	Schedule of Benefits	09-06
HMO/CO GA-6	Group Agreement	07/07
HMO/CO RIDER-RX-2003-1	Prescription Plan Rider	08/02

It appears the Company is not in compliance with Colorado insurance law in that its HMO forms fail to provide a toll free or collect call telephone number within the service area for calls, without charge to enrollees, to the Company's administrative office to adequately provide access for member services, problems, or questions.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to provide a toll free or collect call telephone number of the HMO within the service area for calls to the HMO administrative office, without charge to enrollees, to ensure compliance with Colorado insurance law.

Issue E2: Failure, in some cases, to provide accurate information regarding Newborn and Adoptive Child Enrollment.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

…

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. [Emphasis added.]

(6.5) Adopted child - dependent coverage**.**

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, *the entity shall provide benefits to a child placed for adoption* with an enrollee, policyholder, or subscriber *under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber,* regardless of whether adoption of the child is final. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that its HMO Certificate of Coverage form requires enrollment of newborn and newly adopted children within thirty-one (31) days in order for coverage to continue beyond thirty-one (31) days even though no additional premium would be required to add the additional child.

The Company's Certificate of Coverage includes the following provisions:

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in HMO regardless of health status, age, or requirements for health services within [31-90] days from the eligibility date.

3. Enrollment of Newly Eligible Dependents.

a. Newborn Children.

A newborn child is covered for [31-90] days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in HMO within the initial [31-90] day

period. *If coverage does not require the payment of an additional Premium for a Covered Dependent, the Subscriber must still enroll the child within [31-90] days after the date of birth.* [Emphasis added.]

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this Certificate. Coverage includes necessary transportation costs from place of birth to the nearest specialized Participating treatment center.

b. Adopted Children.

A legally adopted child or a child for whom a Subscriber is a court appointed legal guardian, and who meets the definition of a Covered Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. *The Subscriber must make a written request for coverage within [31-90] days of the date the child is adopted or placed with the Subscriber for adoption.* [Emphasis added.]

Form:		Date:
HMO/CO-COC-7	Certificate of Coverage	07/07

Recommendation No. 4:

Within thirty (30) days the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that the Company's HMO Certificate of Coverage form has been revised to provide accurate information regarding enrollment of newborn and newly adopted dependents as required by Colorado insurance law.

Issue E3: Failure, in some instances, to provide accurate information regarding coverage for dependents to age twenty-five.

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under *twenty-five* years of age, states:

> (1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and *all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child:*
>
> *(a) Has the same legal residence as the parent; or*
>
> *(b) Is financially dependent upon the parent*. [Emphases added]

It appears the Company is not in compliance with Colorado insurance law in that its HMO forms include a provision that requires an unmarried dependent under age twenty-five (25) to be attending a recognized college or university, trade or secondary school on a full-time [and part-time] basis in order to be eligible for dependent coverage. The form does not provide an offer of coverage for a child under twenty-five years of age who meets the above requirements.

The Company's Certificate of Coverage form includes the following provision:

ELIGIBILITY AND ENROLLMENT

A. Eligibility

2. To be eligible to enroll as a Covered Dependent, the Contract Holder must provide dependent coverage for Subscribers, and the dependent must be:
   …
   c. a dependent unmarried child (including natural, [foster,] step, legally adopted children, children placed for adoption, a child under court order, [dependents of dependents,] who meets the eligibility requirements described in this Certificate and on the Schedule of Benefits.

The Company's Schedule of Benefits includes the following provision:

Dependent Eligibility: [A dependent unmarried child [of the Subscriber] as described in the Eligibility and Enrollment section of the Certificate who is:

…

ii. *under [24-30] years of age, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time [and part-time] basis.* [Emphases added.]

Form:		Date:
HMO/CO-COC-7	Certificate of Coverage	07/07
HMO CO SB-7	Schedule of Benefits	09-06

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104.3, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all affected forms to include accurate information regarding the offer of coverage for dependents up to age twenty-five, to ensure compliance with Colorado insurance law.

Issue E4: Failure, in some instances, to provide accurate information regarding the responsibility for tracking copayments.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonability clear; or
>
> …
>
> (XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

It appears that the Company is not in compliance with Colorado insurance law in that its HMO schedule of benefits form requires Members to keep track of their co-payments and demonstrate the copayment amounts that have been paid during the year.

It is the Division's position that this requirement forces the Member(s) to provide information that the Company should already be maintaining or aware of. It is the Company that has the primary responsibility to maintain the records relating to co-payments and when the maximums have been reached in order to properly adjudicate claims. Putting this requirement on the Member places the Member in an adversarial position that may lead to delays and/or improper payment in the settlement of claims, or termination of coverage for cause in the case of unpaid co-payments.

The examiners recognize that it is in the Member's best interest to keep a record of his or her out-of-pocket expenses in order to ensure that they are receiving correct benefit payments; however, as the maximum out-of-pocket expenditure is a contractual provision, it is the Company's responsibility to administer it accurately.

The Company's schedule of benefits form states the following in part:

[The family [Maximum Out-of-Pocket] [Copayment] Limit is based on [2, 3] family members each satisfying the per Member [Maximum Out-of-Pocket] [Copayment] Limit. Once [2, 3] family members have each met their individual [Maximum Out-of-Pocket] [Copayment] Limit, the [Maximum Out-of-Pocket] [Copayment] Limit is considered met for all remaining family members.] ***[Member must demonstrate the Copayment amounts that have been paid during the year.]*** **[Emphasis added.]**	

Form:		Date:
HMO CO SB-7	Schedule of Benefits	09-06

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its schedule of benefits to indicate that it is the Company's responsibility to properly track member copayments, in compliance with Colorado insurance law.

Issue E5: Failure to provide a required Disclosure Notice in the HMO Certificate of Coverage Form.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration -- repeal, states in part:

> (2)(d) *The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:*
>
> (I) *Specific counties of the state where there are no participating providers;*
>
> (II) *The circumstances under which the covered person may be balanced billed by nonparticipating providers; and*
>
> (III) *The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specified covered health services.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its certificate of coverage fails to provide information regarding the specific counties in the state where it has no participating providers; the circumstances under which a covered person may be balance billed by a not participating provider; and the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers as required by Colorado insurance law.

The Company's certificate of coverage provides three conspicuous, bold-faced type notices that state:

> **READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**
>
> **IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY HMO.**
>
> **MEMBER'S WILL BE RESPONSIBLE TO PAY DIRECTLY TO THE PROVIDER COSTS FOR SERVICES OBTAINED BY THE MEMBER WHICH ARE NOT COVERED UNDER THIS CERTIFICATE OR FOR WHICH MEMBER DID NOT OBTAIN THE REQUIRED REFERRAL.**
>
> **NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.**
>
> **THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.**
>
> **PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO.**

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

Form:		Date:
HMO/CO COC-7	CERTIFICATE OF COVERAGE	(07/07)

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its HMO certificate of coverage form to provide all information required in the disclosure notice regarding network adequacy as required by Colorado insurance law.

Issue E6: Failure, in some instances, to provide for coverage to continue after refusal of treatment recommended by a participating provider. *(This was prior issue E3 in the findings of the 2002 final examination report.)*

Section 10-16-102., C.R.S., Definitions, states in part:

> (5) "Basic health care services" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including as a minimum emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

Section 10-16-402, C.R.S., Issuance of certificate of authority – denial, states in part:

> (2)(c) *The health maintenance organization will effectively provide or arrange for the provision of basic health care services* on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, deductibles, and payments for out-of-network services received pursuant to section 10-16-704(2). [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its HMO group agreement form indicates that neither the HMO or a Participating Provider will have further responsibility to provide any of the benefits under the certificate for certain health services otherwise available, including services for conditions resulting from or related to another condition, if a member ended treatment of a Participating Provider. Under Colorado insurance law, the Company cannot refuse to provide necessary treatments that are otherwise covered benefits, solely because a member has refused a recommended procedure.

The Company's Certificate of Coverage states in part:

> C. Refusal of Treatment. A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Provider. If the Participating Provider (after a second Participating Provider's opinion, if requested by Member) believes that no professionally acceptable alternative exists, and if after being so advised, *Member still refuses to follow the recommended treatment or procedure, neither the Participating Provider, nor HMO, will have further responsibility to provide any of the benefits available under this Certificate for treatment of such condition or its consequences or related conditions.*. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the [Claim Procedures/Complaints and Appeals] in this Certificate. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure. [Emphasis added]

Form:		Date:
HMO/CO GA-6	Group Agreement	07/07

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-402, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to remove the provision that ends coverage if treatment is refused and ensures that coverage continues in that event as required by Colorado insurance law.

In the market conduct examination for the period January 1, 2002 to December 31, 2002, the Company was cited for failure to provide for continued coverage of a condition after a member has refused a recommended treatment or procedure. The violation resulted in Recommendation #13 of the Final Agency Order O-05-002 that the Company "shall provide evidence that it has revised all affected forms to provide for continued coverage of a condition regardless of whether or not a member has refused a recommended procedure or treatment to ensure compliance with Colorado insurance law." Failure to comply with the previous order of the Commissioner may constitute a willful violation of §10-1-205, C.R.S.

Issue E7: Failure, in some cases, to provide accurate information regarding coverage for therapies for congenital defects and birth abnormalities.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> (1.7) Therapies for congenital defects and birth abnormalities.
>
> (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that *all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.* [Emphasis added]

It appears that the Company is not in compliance with Colorado insurance law in that its HMO forms, in some cases, indicate coverage for therapies for congenital defects and birth abnormalities is provided to age five (5), instead of to the child's sixth birthday as required by Colorado insurance law.

The Company's policy states:

> Outpatient Rehabilitation Benefits
>
> 4. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, except that coverage *of physical therapy for congenital defects and birth abnormalities in Covered Dependents up to five (5) years of age* is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
>
> 5. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses, except that coverage of *occupational therapy for congenital defects and birth abnormalities in Covered Dependents up to five (5) years of age* is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
>
> 6. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and is subject to the limits, if any, shown on the Schedule of Benefits, except that coverage of speech therapy for congenital defects and birth abnormalities in *Covered Dependents up to five (5) years of age* is without regard to whether the condition is acute or chronic. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered. [Emphases added]
>
> Rehabilitation Therapies for Congenital Defects and Birth Abnormalities
>
> Therapy visits shall be distributed as Medically Necessary for Members *up to five (5) years of age* without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity. [Emphasis added]

Form:		Date:
HMO/CO COC-7	Certificate of Coverage	07/07
HMO CO SB-7	Schedule of Benefits	9/06

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all forms to reflect the correct age for a covered dependent related to therapies for congenital defects and birth abnormalities as required under Colorado insurance law. A self audit should be conducted to ensure that claims for therapies for congenital defects and birth abnormalities were paid properly.

Issue E8: Failure, in some instances, to proscribe the use of genetic testing in connection with a pre-existing condition.

Section 10-3-1104.7, C.R.S., Genetic testing - legislative declaration - definitions - limitations on disclosure of information - liability, states in part:

> (1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:
> …
>
> (d) *The intent of this statute is to prevent information derived from genetic testing from being used to deny access to health care insurance*, group disability insurance, or long-term care insurance coverage.
>
> (3) (b) *Any entity that receives information derived from genetic testing may not seek, use, or keep the information* for any nontherapeutic purpose or *for any underwriting purpose connected with the provision of health care insurance*, group disability insurance, or long-term care insurance coverage. [Emphases added]

It appears that the Company's certificate of coverage form was not in compliance with Colorado insurance law regarding the use of genetic testing information. The Company's form implies that genetic information may be treated as a preexisting condition if there is a diagnosis of the condition related to the information. The certificate states:

> **Limitations**
>
> The preexisting condition limitation does not apply to pregnancy or to a newborn, an adopted child under age 18, or a child placed for adoption under age 18, if the child becomes covered under **Creditable Coverage** within [30-31] days of birth, adoption, or placement for adoption. *Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.* [Emphasis added]

Form:		Date:
HMO/CO COC-7	Certificate of Coverage	07/07

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to proscribe the use of genetic information to determine a pre-existing condition if there is a diagnosis of the condition related to the information, as required under Colorado insurance law.

Issue E9: Failure to correctly define a significant break in coverage in the Certificate of Coverage forms.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) *Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

Section 5. Rules

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, *if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage.* Colorado law prevails over the federal regulations. [Emphasis added]

It appears that the Company's HMO certificate of coverage form is not in compliance with Colorado insurance law in that it defines a significant break in coverage as a variable between sixty-three (63) and ninety (90) days. A significant break in coverage for plans subject to Colorado law is ninety (90) days, while it could be as few as sixty-three (63) days if a member moves to another state. Creditable coverage is used for the purpose of waiving any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by other qualifying creditable policies, and it is important for an individual to know which time period would be applicable to his or her situation.

The Company's HMO certificate of coverage form states in part:

Limitations

> ***HMO*** *waives this preexisting condition limitation provision if, under a prior group [or individual] health benefits plan, there has been a significant break in coverage for not more than a [63-90] consecutive day period*, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. The preexisting condition limitation period will be reduced by the number of days of prior **Creditable Coverage** the **Member** has as of the **Effective Date of Coverage** under this **Certificate**.] [Italicized emphasis added]

The following form does not appear to be in compliance with Colorado insurance law:

Form:		Date:
HMO/CO COC-7	Certificate of Coverage	07/07

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to correctly define a significant break in coverage as required under Colorado insurance law.

Issue E10: Failure to correctly state the member's responsibility for payment of charges for non-covered services for which there was a referral in the Certificate of Coverage form.

Section 10-16-413, C.R.S., Prohibited practices, states in part,

> (1) *No health maintenance organization, or representative thereof, may cause or knowingly permit the use of* advertising which is untrue or misleading, solicitation which is untrue or misleading, or *any form of evidence of coverage which is deceptive.* For purposes of part 1 of this article and this part 4:
>
> …
>
> (c) *An evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole,* and with consideration given to typography and format, as well as language, *shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.* [Emphases added.]

Section 10-16-705, C.R.S., Definitions, states in part:

> (3) Every contract between a carrier and a participating provider shall set forth a hold harmless provision specifying that *the covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no circumstances shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier.* Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayment as specifically provided in the covered person's contract with the managed care plan.
>
> …
>
> (14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:
>
> (a) A provision that clearly states that *the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*;
>
> (15) *A contract between a carrier and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this part 7.* [Emphases added.]

It appears that the Company's HMO certificate of coverage form misrepresents a covered person's liability to pay for non-covered services and is therefore, not in compliance with Colorado law.

The certificate of coverage form states that a covered person who has received medical services based on a referral from a participating provider and for which the Company subsequently determines such services are not covered, results in the member being liable for payment of the service through no fault of his/her own. This provision puts the responsibility for determining which services are covered expenses on the member, instead of correctly placing the responsibility for determining whether or not a service is covered and for obtaining any needed preauthorization on the participating provider as outlined in the § 10-16-705, C.R.S.

The company's form states in part:

Certificate of Coverage

MEMBER'S WILL BE RESPONSIBLE TO PAY DIRECTLY TO THE PROVIDER COSTS FOR SERVICES OBTAINED BY THE MEMBER WHICH ARE NOT COVERED UNDER THIS CERTIFICATE **OR FOR WHICH THE MEMBER DID NOT OBTAIN THE REQUIRED REFERRAL.** [Italicized emphasis added.]

Exclusions and limitations

A. Exclusions

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by rider(s) and/or amendment(s) attached to this **Certificate**:

- *Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.* [Italicized emphasis added.]

Form:		Date:
HMO/CO-COC-7	Certificate of Coverage	07/07

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-413, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of coverage to prohibit billing of a covered person for services received in connection with a referral by a participating provider as required under Colorado insurance law.

Issue E11: Failure, in some instances, to provide accurate information regarding eligibility for conversion coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) *Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a* nonprofit hospital, medical-surgical, and health service corporation or *a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).*

(b)(I) An employee *shall be eligible* to make the election for such employee and the employee's dependents provided for in paragraph (a) of this subsection (2) if:

(A) The employee's eligibility to receive insurance coverage has ended for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;

(B) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and

(C) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.

…

(III) The employer shall not be required to offer continuation of coverage of any person *if such person is covered by Medicare, Title XVIII of the federal "Social Security Act", or Medicaid, Title XIX of the federal "Social Security Act".*

…

(d) *A group contract or group service contract that provides for continued coverage after an employee is terminated,* as required by paragraph (a) of this subsection (2), *shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the insurer underwriting the group*

> *contract or group service contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual service contract or contract providing hospital, medical-surgical, or other health services which shall conform to the same type of descriptions, limitations, and requirements as those specified for converted policies pursuant to subparagraph (I) of paragraph (c) of subsection (1) of this section.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its HMO Certificate of Coverage form provides that Members do not have the right to conversion coverage if they are eligible for Medicare at the time their coverage terminates.

Colorado insurance law states that an offer of coverage need not be extended if Medicare already covers the Member when they become eligible for conversion coverage. However, as Medicare is not "group" coverage, the carrier is not allowed to refuse an offer of conversion coverage solely because a Member is eligible for Medicare.

The Company's Certificate of Coverage form provides for conversion of coverage as follows:

CONTINUATION OF COVERAGE

[H] Conversion Privilege

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

3. Members who are eligible for Medicare at the time their coverage under this certificate is terminated are not eligible for conversion

Form:		Date:
HMO/CO COC-7	Certificate of Coverage	07/07

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of coverage to provide for conversion of insurance for Members who are eligible, but not actually covered by Medicare as required under Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS

Issue H1: Failure to reflect a complete definition of a "significant break in coverage" in certificates of creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) *Shall waive any* affiliation period or *time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule.* [Emphases added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.* [Emphasis added.]

Section 5. Rules

B. Colorado law concerning creditable coverage.

3. *Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state.* The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphases added]

LARGE GROUP TERMINATED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage of sample
5,868	116	116	100%

The examiners reviewed a sub-sample of 116 certificates of creditable coverage from a total population of 5,868 members from ninety-seven (97) groups whose health benefit plans had terminated.

It appears the Company is not in compliance with Colorado insurance law in that the form sent to members of terminated groups as a certificate of creditable coverage titled "Certificate of Prior Health Coverage" does not reflect the full definition of "significant break in coverage" as provided in Section 4. A. of Colorado Insurance Regulation 4-2-18. The Company's definition does not state that if an insured leaves Colorado, a significant break in coverage may be as short as sixty-three (63) days.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all Certificates of Creditable Coverage reflect the complete definition of a "Significant break in coverage" in compliance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5., C.R.S, Prompt Payment of Claims – legislative declaration states, in part:

> (2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> …
>
> (4)(a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*
>
> (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).
>
> (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

EXAMINER COMMENT: It appears the Company is not in compliance with Colorado insurance law in that:

ELECTRONIC CLAIMS ADJUDICATED 30 DAYS OR MORE AFTER RECEIPT

Population	Sample	Number of Exceptions	Percentage of sample
3,655	108	51	47%

Fifty-one (51) of 108 claims randomly selected from the total population of 3,655 electronic claims adjudicated more than thirty (30) days after receipt appeared to be clean claims that were not paid, denied

or settled within the required time frame.

In these fifty-one (51) instances, the examiner's review indicated that the claims noted as exceptions appeared to meet the definition of a "clean" claim as set forth in §10-16-106.5 (2), contrary to any system coding by the Company.

NON-ELECTRONIC CLAIMS ADJUDICATED 45 DAYS OR MORE AFTER RECEIPT

Population	Sample	Number of Exceptions	Percentage of sample
2,467	108	75	69%

Seventy-five (75) of 108 non-electronic claims randomly selected from the total population of 2,467 non-electronic claims adjudicated more than forty-five (45) days after receipt appeared to be clean claims that were not paid, denied or settled within the required time frame. In some cases, the examiner's review indicated a claim was determined unclean by the Company in error because the information requested in a pending notice was provided with the original claim submission. In other cases there was no copy of a request for additional information sent to the member or the provider. In still other cases when it appeared additional information may have been needed, but no request for additional information was found, the Company advised the examiners no further information was required to adjudicate the claim.

CLAIMS ADJUDICATED 90 DAYS OR MORE AFTER RECEIPT

Population	Sample	Number of Exceptions	Percentage of sample
1,274	108	102	94%

It appears that the Company is not in compliance with Colorado insurance law in that it failed to pay, deny or settle 102 of 108 claims randomly selected from a total population of 1,297 claims not paid, denied or settled within the required ninety (90) calendar days. There was no indication in the claim records that any of the cited claims involved fraud. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all claims are adjudicated within the required time periods as required by Colorado insurance law.

Issue J2: Failure, in some cases, to pay late payment interest and/or penalties on claims not processed within the required time periods.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent* of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

*Note that this penalty was ten (10) percent until it was increased to twenty (20) percent per statute. See L. 2008: (5)(b) amended, p. 2174, §7, effective August 5, 2008.

PAID ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
3,655	108	16	15%

It appears the Company is not in compliance with Colorado insurance law in that:

Sixteen (16) of 108 claims randomly selected from a population of 3,655 electronic claims adjudicated more than thirty (30) days after receipt appeared to be clean claims where interest in the amount of ten (10) percent per annum was owed but not paid on the amount ultimately allowed by the Company.

In these sixteen (16) instances, the examiner's review indicated that the claims noted as exceptions appeared to meet the definition of a "clean" claim as set forth in §10-16-106.5 (2), contrary to any system coding by the Company.

PAID NON-ELECTRONIC CLAIMS PROCESSED OVER 45 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
2,467	108	18	17%

The examiners determined that of the 108 claims randomly selected from the total population of 2,467 non-electronic claims adjudicated more than forty-five (45) days after receipt, interest was owed but not paid on eighteen (18) claims ultimately paid as indicated below:

- Fourteen (14) claims appeared to be clean claims that were not paid within the required forty-five (45) days.
- One (1) claim appeared to be clean and incorrectly denied more than thirty (30) days after receipt of the claim. Although the claim was ultimately paid, interest was owed but not paid on the amount allowed.
- Three (3) claims appeared to be unclean, but the notices requesting additional information were sent more than thirty (30) days after receipt of the claim. Therefore, although the claims were ultimately paid, interest was owed but not paid on the amount allowed.

PAID CLAIMS PROCESSED OVER 90 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
1,274	108	69	64%

The examiners identified a total summarized population of 1,274 claims paid, denied or settled in excess of ninety (90) calendar days during the examination period. A random sample of 108 such claims was selected for review.

Upon review of the 108 claims, the examiners determined that a penalty payment was due in sixty-nine (69) instances. It appears that the Company is not in compliance with Colorado insurance law in that it failed to pay a penalty of ten percent (10%) for claims adjudicated prior to August 5, 2008 and twenty percent (20%) for claims adjudicated on or after August 5, 2008 of the amount allowed on the claims.

Of the seventy-one (71) claims that were not in compliance with Colorado insurance law:

- Fifty-six (56) claims had no penalty paid to the insured or health care provider on the ninety-first (91st) day, as required, and should have been paid at the 10% penalty rate.

- Eight (8) claims had no penalty paid to the insured or health care provider on the ninety-first (91st) day, as required, and should have been paid at the 20% penalty rate.

- Five (5) claims paid a penalty to the insured or health care provider on the ninety-first (91st) day, as required, but these claims were paid at the 10% penalty rate instead of the appropriate 20% rate.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that correct late payment penalties are paid in all applicable instances as required by Colorado insurance law. A self audit should also be performed to properly pay all late payment penalties owed.

Issue J3: Failure, in some cases, to send a written explanation within thirty (30) calendar days after receipt of an unclean claim, and/or failure to give a full and correct explanation of what additional information is needed to resolve the claim.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

…

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

NON-ELECTRONICALLY RECEIVED PAID CLAIMS PROCESSED OVER 45 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
2,467	108	8	7%

It appears that, in some cases, the Company is not in compliance with Colorado insurance law in its handling of unclean non-electronic claims which required additional information to determine the Company's liability. Of the 108 claims randomly selected from the total population of 2,467 non-electronic claims adjudicated more than forty-five (45) days after receipt, eight (8) claims were not in compliance with regard to requesting additional information or documentation. In seven (7) instances the required information was requested more than thirty (30) days after receipt. In the eighth instance, information in the notice was incorrect and misleading and was not specific as to what was needed.

In addition, in the seven (7) of eight (8) files in which the request for additional information was sent late, the documentation indicates they were closed immediately after mailing the pending notice. One (1) of those was a file for which a request for additional information (D61 letter) was not sent, and the required documentation was therefore not provided. Since the claim was closed and no further notice was sent, the claim remained closed and was never fully adjudicated. It appears the required information was not provided for four (4) other files for which information was requested but no notices indicating the claims were denied for lack of that information were sent, resulting in a total of five (5) of the eight (8) files not being fully adjudicated.

Colorado insurance law requires carriers to request additional information needed to adjudicate a claim within thirty (30) calendar days after receipt of the claim; to make such request in writing; and to include a full explanation in that request of what is needed to resolve that claim. If the request for additional information is not made within thirty (30) days, the Company then owes interest on any amount ultimately paid on the claim when it is paid.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that a request for additional information is sent as required for all unclean claims as required by Colorado insurance law.

Issue J4: Failure, in some cases, to provide true and accurate statements in provider and/or member notices regarding the reasons claims were denied.

Section 10-3-1104, C.R.S, Unfair methods of competition and unfair or deceptive acts or practices states in part:

(1) *The following are defined* as unfair methods of competition and *unfair or deceptive acts or practices in the business of insurance:*

…

(b) *False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the publi*c, in a newspaper, magazine, or other publication, or *in the form of a notice*, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, *or statement containing any assertion, representation, or statemen*t with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, *which is untrue, deceptive, or misleading;*

…

(h) *Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:*

(I) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; or [Emphases added.]

Section 10-16-113, C.R.S, Procedure for the denial of benefits – rules, states in part:

(2) Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing.

DENIED CLAIMS

Population	Sample	Number of Exceptions	Percentage of sample
61,744	109	12	11%

It appears that in some cases, the Company is not in compliance with Colorado insurance law in that twelve (12) of 109 denied claims randomly selected from the total population of 61,774 denied claims had denial notices sent to the provider with incorrect information or information differing from the information provided to the member regarding the denial.

Eleven (11) of the notices sent to the provider indicated that services by a non-participating provider were not covered unless pre-certified. The corresponding notices to the members indicated that specialist or hospital services were covered only if an electronic or written referral was issued by the member's primary care physician or necessitated by a medical emergency. There is a difference between a referral by a primary care physician and a pre-certification by a non-participating provider. Providing information to the provider that differs from the information provided to the member is incorrect, misleading and deceptive.

One (1) claim appeared to be a request for reconsideration in which the previous denial of the claim was upheld. No record of a denial of a claim for this date of service for this member and for this provider prior to the denial in the sample was provided. It is unclear what previous decision was being upheld since this claim had not been fully adjudicated. Therefore, it appears the information given to the provider was false, misleading and potentially deceptive.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its claim payment procedures to ensure that accurate information regarding the reason(s) a claim was denied is provided to both providers and members.

Issue J5: Failure, in some instances, to pay eligible charges on claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part**:**

(1) *The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:*

…

(h) *Unfair claims settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:*

…

(IV) *Refusing to pay claims without a conducting a reasonable investigation based upon all available information,*

...

(VI) *Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear*; or [Emphases added.]

Section 10-16-407, C.R.S., Information to enrollees states, in part:

(2**)** Every health maintenance organization shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. *No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.* [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, states in part:

Section 8.Emergency Services

A. *A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person having average knowledge of health services and medicine and acting reasonably*

would have believed that an emergency medical condition or life or limb threatening emergency existed. Under these same circumstances a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.

B. *Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of Section 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.* [Emphases added,]

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in states in part:

Section 4. Definitions

C. "*Emergency services" means health care services provided in connection with any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.*

DENIED CLAIMS

Population	Sample	Number of Exceptions	Percentage of sample
61,744	109	12	11%

It appears the Company is not in compliance with Colorado insurance law in that twelve (12) of 109 denied claims randomly selected for review from the total population of 61,734 denied claims appear to have been incorrectly denied. The examiners' analysis of these exceptions is outlined below:

- In three (3) cases, emergency service claims were denied. In one (1) of those cases, the reason for denial was failure to provide medical records requested when those records had actually been provided twice prior to the denial.

- In one (1) case, the claim was denied as a non-billable separate laboratory charge.

- In five (5) cases, the claims were denied in error due to inaccurate company records or incorrect interpretation of existing contracts.

- In two (2) cases, the claims were denied for lack of precertification or referral when precertification or referral had been received or was not required. In one (1) of those cases referral was not required because the treating provider was the member's PCP.

- In one (1) case, the claim was denied as a separate professional component when the contract specifically allows payment for this benefit.

Colorado insurance law requires prompt, fair and equitable settlement of all claims in which liability has become reasonably clear. In addition, HMOs are required to cover emergency care provided in connection with any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. Consumers should be held harmless and not be subject to balance billing for emergency services since they are covered benefits, regardless of where they are provided. When the covered person is balance billed by a non-network provider for any charges that have been denied by the carrier, the carrier should also hold the covered person harmless. The carrier may investigate the billing, dispute the billing or subrogate against any other liable party to recover any amount paid. While that is ongoing, the bill must be paid to hold the member harmless in the process. This includes separate "professional" charges, transportation charges and emergency services required due to a motor vehicle accident. The Company must apply the definition of emergency services provided in Colorado insurance law to determine whether emergency services were required and whether subrogation is appropriate.

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-407 C.R.S., and Colorado Insurance Regulations 4-2-17 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its claim payment procedures to ensure that all eligible charges are paid when due. The Company should also be required to perform a self-audit of all claim denials to ensure that any eligible charges that were incorrectly denied are paid.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to provide a written notice to the covered person at least twenty (20) days prior to the scheduled review date.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision…

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(1) The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. *The covered person shall be notified in writing at least twenty (20) days in advance of the review date.* The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person. [Emphases added.]

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Issues	Percentage of Sample
9	9	5	56%

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company was not in compliance with Colorado insurance law in that in five (5) of the nine (9) files reviewed, the Company failed to provide written notice to the covered person at least twenty (20) days prior to the scheduled review date.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that notice of all second level review meetings are provided at least twenty (20) days in advance of the review date.

Issue K2: Failure, in some instances, to ensure that the second level review panel is comprised of health care professionals with the appropriate expertise in relation to the case being presented.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 4. Definitions

J. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Section 11. Voluntary Second Level Review

F. Procedures

1. With respect to a voluntary second level review of a first level review decision, the denial shall be reviewed by a health care professional (reviewer) or, if offered by the health carrier, *a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person*… [Emphasis added.]

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	3	33%

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company was not in compliance with Colorado insurance law in that in three (3) of the nine (9) voluntary second-level utilization review decisions reviewed, the Company failed to ensure that the review panel was comprised of health care professionals with the appropriate expertise in relation to the case being presented. It appears that the use of case managers and appeal analysts did not meet the criteria of "health care professionals" as outlined in Colorado Insurance Regulation 4-2-17, and do not possess "appropriate expertise in relation to the case presented by the covered person". Additionally, while nurses do meet the criteria of "health care professionals", the Company failed to establish that they possess the "appropriate expertise" as required by Colorado insurance law.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all second level review panels are comprised of health care professionals with the appropriate expertise in relation to the case being presented.

Issue K3: Failure, in some instances, to include the names, titles or qualifying credentials of the reviewer or members of the review panel in the Company's second level review decision notification letter.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

H. A decision issued pursuant to Subsection G shall include:

(1) *The names, titles and qualifying credentials of the reviewer or members of the review panel*… [Emphasis added]

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	4	44%

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company was not in compliance with Colorado insurance law in that in four (4) of the nine (9) voluntary second-level utilization review decisions reviewed, the Company's decision notification letter and/or attachment provided to the covered person and/or their representative(s), did not contain the names, titles or qualifying credentials of the reviewer or members of the review panel as set forth in Colorado Insurance Regulation 4-2-17(11)(H)(1).

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its second level review decision notification letter and/or attachment provided to the covered person and/or their representative(s), to provide the names, titles or qualifying credentials of the reviewer or members of the review panel as required by Colorado insurance law.

Issue K4: Failure, in some instances, to demonstrate an understanding of a covered person's request for review, and failure to provide the procedures for obtaining an independent external review of an adverse determination. ***(This was prior issue K8 in the findings of the 2002 final examination report and K3 in the previous 2000 final examination report)***

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

H. A decision issued pursuant to Subsection G. shall include:

…

2. A *statement of the reviewer's or the review panel's understanding of the covered person's request for review of an adverse determination*;

…

5. For a voluntary second level decision issued involving an adverse determination:

…

a. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rational;

b. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Section 10.F.2., to the covered person's benefit request;

c. If the reviewer or review panel has relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

d. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge;

e. If applicable, instructions for requesting

i. A copy of the rule, guideline, protocol or similar criterion relied upon in making the adverse determination, as provided in Subparagraph c. of this paragraph; and

ii. The written statement of scientific or clinical rationale for the determination, as provided in Subparagraph c. of this paragraph;

f. *A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21*. [Emphases added.]

VOLUNTARY SECOND LEVEL REVIEW

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	1	11%

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) conducted during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company was not in compliance with Colorado insurance law in that in one (1) of the nine (9) of the files reviewed, the Company failed to meet the disclosure requirements set forth in Colorado Insurance Regulation 4-2-17 with regard to an adverse benefit determination. Specifically, the Company failed to demonstrate an understanding of the covered person's request for review and failed to provide the procedures for obtaining an independent external review of the adverse determination.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that the Company demonstrates an understanding of the covered person's request for review, and provides the procedures for obtaining an independent external review of an adverse determination as required by Colorado insurance law.

Issue K5: Failure, in some instances, to include the name, title and qualifying credentials of the physician who evaluated the appeal and/or the qualifying credentials of the clinical peer(s) with whom the physician consulted in first level review decision letters. ***(This was prior issue K8 in the findings of the 2002 final examination report and K3 in the previous 2000 final examination report)***

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

I. The decision issued pursuant to Subsection G, shall set forth in a manner calculated to be understood by the covered person:

(1) *The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults.* [Emphasis added]

The examiners reviewed the entire population of 109 first-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

FIRST LEVEL REVIEW

Population	Sample	Number of Exceptions	Percentage of Sample
109	109	49	45%

It appears that the Company was not in compliance with Colorado insurance law in that in forty-nine (49) of the 109 first-level review decisions, the Company's decision notification letter and/or attachment did not contain the names, titles or qualifying credentials of the physician that evaluated the appeal, and/or the qualifying credentials of the clinical peer(s) with whom the physician consulted.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to include the name, title and qualifying credentials of the physician who evaluates the appeal and/or the qualifying credentials of the clinical peer(s) with whom the physician consults as required by Colorado insurance law.

In the market conduct examinations calendar years 1998 and 2002, the Company was cited for failure to include all required information in written notification letters sent to members and providers regarding first level reviews. These violations resulted in Recommendation #59 of Final Agency Order O-00-293, and #29 of the Final Agency Order O-05-002 that the Company "shall provide evidence that it has revised its procedures to ensure that level one written notification letters contain all required information as required by Colorado insurance law." Failure to comply with the previous orders of the Commissioner may constitute a willful violation of §10-1-205, C.R.S.

Issue K6: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

E. Conduct of first level reviews.

1. *First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer.* The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. *[Emphasis added]*

FIRST LEVEL REVIEW

Population	Sample	Number of Exceptions	Percentage of Sample
109	109	14	13%

The examiners reviewed the entire population 109 first-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company was not in compliance with Colorado insurance law in that in fourteen (14) of the 109 first-level utilization review decisions did not reflect a consultation with an appropriate clinical peer, nor was the physician that conducted the review a clinical peer.

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to include a consultation with an appropriate clinical peer when evaluating first level review appeals, unless the reviewing physician is a clinical peer as required by Colorado insurance law.

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Examination Report Submission

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